

ANMF Submission to the Nursing and Midwifery Board of Australia Consultation

PROPOSED DECISION- MAKING FRAMEWORK FOR NURSES AND MIDWIVES

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of 275,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The Federation welcomes the opportunity to provide a response to the Nursing and Midwifery Board of Australia (NMBA) public consultation on the proposed Decision-making framework (DMF) for nurses and midwives.

In October 2018, the ANMF conducted a survey of our members regarding their understanding and use of the current DMF. Responses indicate the need for considerable work to be undertaken to improve the knowledge of, and use of this important resource.

This review will enable the NMBA to provide nurses and midwives with much needed clarity and direction in relation to their individual scope of practice. Nurses and midwives should be able to use the DMF to understand their accountability and responsibility for supervision and delegation of care when working with enrolled nurses, students of nursing, students of midwifery and with care workers.

Once this review is completed, the DMF must be a mandatory component of all undergraduate education for nurses and midwives. It is imperative that the NMBA provides the current workforce of nurses and midwives with comprehensive education regarding use of the DMF so that it can be effectively embedded into daily practice.



QUESTIONS FOR FEEDBACK

1. Is the proposed DMF more helpful, clear and usable in practice when compared to the national framework?

The proposed DMF is an improvement on the existing documentation and guidance. However, as detailed further in our response, there are areas of ambiguity and some sections that lack clarity. The ANMF support the proposed DMF, contingent on acceptance of the changes requested.

Suggested amendments

PAGE 2

The first sentence of the last paragraph under 'Background' should be amended to "The DMF establishes a foundation for decision-making that is based on competence and the provision of quality care."

Another useful dot point would be to include skills and scope of practice of self and others. The language used regarding the requirements of the National Law needs to be strengthened, specifying that registered nurses and midwives cannot delegate clinical care to health workers, as they do not have the education, skills, or accountability to perform the tasks. See also our response to question 10 detailing the feedback and comments of our surveyed members regarding their familiarity and use of the DMFs.

PAGE 4

Point 6 should include evidence as a contributor to changes in practice. The final line in point 6 concerns the ANMF, as employers (who are not professionally qualified and registered nurse or midwife managers, for example) ought not be delegating practice to, nor accepting delegation from nurses or midwives.

2. Does the proposed DMF adequately include the person/woman receiving care in the decision-making?

The proposed framework has consistently centred the person or woman receiving care in the decision-making process.

3. Does the 'Guide to delegation decisions' within the proposed DMF clearly identify the delegation roles and responsibilities of the registered nurse and midwife?

For the most part the proposed DMF has articulated the ultimate responsibility of delegated actions, that delegatory authority rests with the registered nurse or midwife (and actions cannot be re-delegated to a third person without consultation and approval by the delegator), and the requirements and attributes of the person being delegated to.



Suggested amendments

PAGE 9

We draw attention to the references, in paragraphs 1 and 2, of delegation to “another member of the healthcare team from a different discipline”. While we agree that there is overlap in scope of practice between different members of the health care team in regards to some specific tasks, it is the position of the ANMF that nursing and midwifery care may only be performed by nurses and midwives respectively.

As discussed below, there are some sections where these delegation roles and responsibilities are not made clear, and require additional or alternate wording (as suggested by the ANMF). In addition, as detailed in our response to question 10, a tool is only of use if its target audience is aware of it, and knows how to use it. A study of our members demonstrated that there are currently significant knowledge gaps amongst registered nurses, enrolled nurses and midwives about the national framework and flow charts. If the proposed model is accepted, the NMBA has considerable work to do to improve workforce knowledge and capacity regarding understanding and use of the framework.

4. Does the ‘Guide to delegation decisions’ within the proposed DMF clearly define the relationship and responsibilities of the enrolled nurse?

The ANMF considers that the relationship and responsibilities of the enrolled nurse are, for the most part, well-articulated in the proposed revision of the DMF, which explains the duties and responsibilities of both parties in the in acts of delegation of nursing activities to the enrolled nurse.

Suggested amendments

However, we do seek some amendments for this component of the framework, as follows:

PAGE 9

- While we appreciate that the opening sentence of the guide to delegation decisions is written with the intent of placing nursing and midwifery decisions around delegation within a broader health context, the inclusion of the term “multidisciplinary healthcare team” creates potential confusion regarding other healthcare practitioners delegating elements of their practice to nurses and midwives, and to the misunderstanding that nursing and midwifery care can be performed by non-nurses and non-midwives.
- Similarly, the use of “another health practitioner” at the end of the third paragraph does not detail that supervision for delegated care cannot be replaced or substituted by other people additional to nurses, midwives, and other health practitioners.



- Paragraph 5 discusses the difference between delegation and allocation or assignment – this is an important distinction, and misunderstanding how the two differ has the potential for people to assume or delegate without sufficient thought or care. For this reason, a definition of what allocation/assignment is, and is not, should be included in the glossary.
- The concepts in paragraph 6 are also highly important, but not particularly well worded here. The ANMF seeks improved clarity, and suggests:
- “The registered nurse or midwife retains accountability for supervision, performance, and evaluation of the delegated action. This means that a person cannot themselves re-delegate an action or care, but must consult with the registered nurse or midwife, who then begins the delegation process anew. This is the case unless the second person has gained autonomous authority to perform the activity themselves, and any delegation by them meets all the requirements for the original delegation. This means, for example, that an enrolled nurse cannot re-delegate an activity to a registered nurse, even if the EN has considerable experience and the RN is a novice.”
- Paragraph 7 would benefit from the addition of the sentence “Supervision of any activities delegated to a student nurse or student midwife must be performed by a registered nurse or midwife, respectively.”
- The information in paragraph 8 is extraordinarily important and should be emphasised throughout the guide.

PAGE 11

- We note that a subtle but problematic shift in terminology has occurred, whereby unambiguous references in the current DMF to ‘non-nurse’ and ‘non-midwife’ have been changed to ‘health worker’. The ANMF does not support this change in terminology, as there are members of the team (e.g. patient care workers, however titled) who are not categorised as health workers.
- Please add “or student” to references to health workers throughout delegation phase 4 and associated actions, as they may be delegated to but are not health workers.
- The final paragraph discusses documentation and an evaluation process for all delegated decisions. It is the position of the ANMF that there is an absence of substantial evidence that this step is useful or necessary. This is an unrealistic and unreasonable component that will not be adhered to, as delegation decisions are made multiple times by many nurses and midwives most days. Instead, we suggest this aspect only apply to *significant* delegation decisions, determined based on the clinical importance of the delegated action (factoring in the action and the condition of the person receiving care).



5. Does the ‘Guide to nursing practice decisions’ within the proposed DMF provide clear direction when making decisions about nursing practice?

The proposed DMF offers a summary of the processes and considerations required when making clinical care decisions, rather than genuine guidance.

Suggested amendments

PAGE 5

Adding “in a safe manner” to statement 1 of the guide would more closely align the framework with best practice. We are pleased with the concept and description of the first action relating to this statement. Please precede “professional standards” with “nursing” in action two of statement two on this page.

We have a number of concerns regarding the third statement and corresponding actions, specifically:

- Reference to employer-driven extension of practice – there is no reference to safety, clinical risk, or the need for evidence to support these changes, which have significant industrial and professional implications for our members, beginning with the need for consultation and (potentially) a need for further individual education and support.
- A group of expert, experienced staff had difficulty consistently and coherently interpreting action 1, “the activity is within the current contemporary scope of nursing practice and the standards for practice would support the nurse performing the activity.” This action directly contradicts the statement made immediately prior in the stem. We have therefore formed the position that clinicians, who may be referring to the framework in times of exigency, would likely have greater difficulty understanding the intent of this sentence.
- The phrase ‘accepted contemporary scope of nursing practice,’ potentially signposts out-of-scope practice by nurses believing that (having utilised the framework) they are acting in an NMBA-approved manner.
- ‘certifications’ (action 3 of statement 3) are not defined in the glossary, and are not universally applicable; the ANMF request this be replaced with “qualifications”.
- Action 4 of point 3 allows assessment of a potential delegatee’s competence to be performed by a health professional or provider “*who may be a more experienced/qualified nurse*” (emphasis added). This is not acceptable to the ANMF, as it is registrants within the profession who determine nursing competence, not other health professionals or providers. This language may facilitate non-registrants (e.g. aged care providers, who are under no obligation to have any health care knowledge, far less registration) to determine nurse competence.



PAGE 9

We draw attention to the references, in paragraphs 1 and 2, of delegation to “another member of the healthcare team from a different discipline.” While we agree that there may be overlap in scope of practice between different members of the health care team in regards to some specific tasks, it is the position of the ANMF that nursing and midwifery care may only be performed by nurses and midwives respectively. As the DMF is intended as a guidance for nurses and/or midwives, it is our view that it should be emphasised here that such a circumstance is more the exception than the rule

6. Does the ‘Guide to midwifery practice decisions’ within the proposed DMF provide clear direction when making decisions about midwifery practice?

The DMF offers a summary of the processes and considerations required when making clinical care decisions, rather than a guide. The addition of examples to the guide of the DMF in practice would increase both its usability and helpfulness, by illustrating how the principles of clinical decision making translate into practice.

Suggested amendments

PAGE 7

Adding “in a safe manner” to statement 1 of the guide would more closely align the framework with best practice. We are pleased with the concept and description of the first action relating to this statement. Please precede “professional standards” with “midwifery” in action two of statement two on this page.

We have a number of concerns regarding the third statement and corresponding actions, specifically:

- Reference to employer-driven extension of practice – there is no reference to safety, clinical risk, or the need for evidence to support these changes, which have significant industrial and professional implications for our members, beginning with the need for consultation and (potentially) a need for further individual education and support.
- A group of expert, experienced staff had difficulty consistently and coherently interpreting action 1, “the activity is within the current contemporary scope of midwifery practice and the standards for practice would support the midwife performing the activity.” This action directly contradicts the statement made immediately prior in the stem. We have therefore formed the position that clinicians, who may be referring to the framework in times of exigency, would likely have greater difficulty understanding the intent of this sentence.
- The phrase ‘accepted contemporary scope of midwifery practice,’ potentially signposts out-of-scope practice by midwives believing that (having utilised the framework) they are acting in an NMBA-approved manner.



- ‘certifications’ (action 3 of statement 3) are not defined in the glossary, and are not universally applicable; the ANMF request this be replaced with “qualifications”.
- Action 4 of point 3 allows assessment of a potential delegatee’s competence to be performed by a health professional or provider “*who may be a more experienced/qualified midwife*” (emphasis added). This is not acceptable to the ANMF, as it is registrants within the profession who determine midwifery competence, not other health professionals or providers. This language may facilitate non-registrants to determine midwife competence.

PAGE 11

Two considerations have been removed from action 4: that there be consensus in the profession regarding non-nurse or non-midwife performance of the activity under consideration, and that the competence of a non-nurse or non-midwife be assessed by a nurse or midwife (respectively) as part of the decision-making process. The ANMF is not supportive of the removal of these components, as this hands over assessment of the non-nurse or non-midwife’s competence and capacity to perform a delegated activity to another health professional or a provider, without the requirement that they be a nurse or midwife. As final accountability for delegation rests with the nurse or midwife, all aspects of the decision-making process must be made by a nurse or midwife (respectively).

7. Is the proposed *Decision-making framework: summary for nurses* more helpful, clear and usable in practice compared to the current nursing practice summary guide?

Yes, provided the gaps identified are addressed:

Identify need/benefit

- Add “parent, or designated health decision maker” to point 2 regarding consent

Reflect on scope of practice and midwifery standards

- Add “is this evidence-based best practice.”

Consider context of practice/governance/identification of risk

- Part two of point 1 refers to students’ education facilities – their policies will not necessarily be known by the nurse making decisions around delegation, making them reliant on the student’s knowledge for confirmation



Select appropriate, competent person to perform activities

- Define “autonomous” (as used here) in the glossary
- Change the language at point 1 of from “health workers” to “health workers and other non-nurse health practitioners”
- Move “is the person competent and confident in performing the activity and accepting the delegation” to the last point, as the other questions need to be answered before the potential delegator can make the decision to delegate

Yes actions

- Add “provide supervision.”

8. Is the proposed *Decision-making framework: summary for midwives* more helpful, clear and usable in practice compared to the current midwifery practice summary guide?

Yes, provided the gaps identified are addressed:

Reflect on scope of practice and midwifery standards

- Add “is this evidence-based best practice.”

Select appropriate, competent person to perform activities

- Define “autonomous” (as used here) in the glossary
- Change the language at point 1 from “health workers” to “health workers and other non-midwife health practitioners.”
- Move “is the person competent and confident in performing the activity and accepting the delegation” to the last point, as the other questions need to be answered before the potential delegator can make the decision to delegate

Yes actions

- Add “provide supervision.”

9. Are the essential components from the national framework practice decision flowcharts captured in the proposed DMF summaries?

Yes.



10. Please share any other comments you have on the proposed DMF and DMF summaries.

While the current DMF is a useful tool, our research suggests that the majority of nursing and midwifery practitioners do not access, utilise, understand, or even know about its existence. Of critical importance is the matter of delegation: the core of the DMF is ensuring that both those delegating and those accepting delegated duties have a full appreciation of the associated responsibility, accountability, and need for supervision (where relevant) when accepting a delegated nursing or midwifery activity.

In 2018 the ANMF conducted a member survey regarding awareness and use of the current DMF. Almost 80% of respondents were registered nurses (including 2.3% nurse practitioners), with roughly equal numbers of enrolled nurses and midwives accounting for the remainder. Forty-two percent of participants had either not heard of, or were not sure if they had heard of, the DMF and the same percentage nominated (of seven choices and the option to select multiple responses) the DMF as a/the document they would refer to “to help you understand your role in delegation and supervision.”

Our members reported widespread lack of awareness of the Framework:

“Yes, but only in the last year. I was unaware of the document previously. I wish I had been, as it clearly assists to make decisions,” “Registered nurses and enrolled nurses generally do not have a good understanding of the DMF principles and how to apply the principles to practice...” and “The main issue is that generally registered and enrolled nurses do not read the DMF and use the framework in practice,” along with multiple iterations along the lines of “I didn’t know it was available,” and “Never heard of them before today.”

They also criticised the current Framework as being too technical, too complicated, confusing, or not applicable to clinical issues, with comments including:

“It is in complex language that makes it difficult to understand the important points,” “The flow chart is too busy,” “the [Frameworks] are ridiculously [sic] user unfriendly, It’s so frustrating we can’t have a plain language version,” “The wording is ambiguous,” “I think there needs to be more clarity,” “The wording’s ambiguous and does not provide clear direction in many cases; people interpret the document differently,” “Delegation in midwifery ie from a midwife to a non-midwife, is not completely clear,” and “Because the consequences are so critical if you work outside your SoP then NMBA have a responsibility to make the guidelines clear and understandable.”

The theme of the Framework lacking applicability was mentioned several times:



“It can’t help me make any decisions because it’s useless mumbo jumbo. I don’t know anybody who can use it, I had a problem at work and referred to it. Was very disappointed,” “Not practical for day to day clinical application. However, a good resource to problem [solve] clinical decisions when reflecting on clinical issues or planning,” and “DMF does not tell you how to address if an employer instructs you to delegate; the only option is to leave ie lose my job, because the DMF places my registration at risk and not the organisation that refuses to acknowledge the national law.”

Some requested requirements that the DMF be consulted in specific situations:

“The DMF is usually not considered by the organisation in a change impact statement, even in circumstances that nursing practice or service is change[d] to a different location. I recommend that NMBA provide very strict guidance to require organisations to use the DMF in all [applicable] situations.”

Clarity around scope of practice was another recurrent theme:

“It would be really good to have clarity around medication roles for ENs and RN[s] that are in line with current legislation and not outdated legislation,” and “I think the scope of the Framework needs to be broader, What staff struggle with on a day to day basis is understanding the differences between ENs and RNs from a professional practice perspective, and the implications of these...”

Many of the responses centered on reinforcing and clarifying scopes of practice, both their own and their colleagues:

“Just to have the scope of practice would be great; it seems my scope is whatever others tell me it is,” “I recently changed in area to working with personal care workers – very unclear boundaries of roles,” “Explaining medication management in aged care vs medication administration, wound management vs wound assessment by an RN,” and “Midwives and nurses need to understand their own scope – many nurses... think midwifery is a branch of nursing: it’s NOT!”

That the responsibilities and role of delegation are not fully understood is illustrated by the following responses to the question of whether RNs in their area of practice supervise and delegate care to ENs:

“ENs often practice autonomously within [my area of practice] – I have had many discussions with the unit manager about this,” “This is more in theory and practice because they’re geographically isolated,” “{There are not] RNs on every shift, ENs are team leaders,” “I find EENs don’t like or want to adhere or listen to the DMF delegation rules,” and “I work in the community health centre and I work individually, not under the supervision of an RN.” This is not only an issue within nursing: “The delegation pathway is not recognised by [doctors], seeing EENs within their delegation pathway and bypassing RNs,”



When asked a similar question about delegating their care to non-midwives, including ENs and assistants in midwifery, midwife participants responded that the Framework should include delegation by midwives to registered nurses, noting the two professions often work alongside each other in special care nurseries, and two respondents mentioned delegation to mothercraft nurses.

It is also evident that interpreting the DMFs is informed by the reader's role, without consideration being given to their position (or potential position) as being delegated to as well as being a delegator:

"As a graduate it is rare I'm put in a position to delegate tasks," "It does not apply to students, therefore it's misinterpreted by RNs who won't let students undertake certain activities," and "The language is ambiguous at times, meaning students especially interpret the DMF through only their point of view, not that of the profession or the workplace."

Worryingly, a quarter of respondents reported having been instructed by their employer to, on at least one occasion, practice in a way that contravened or was inconsistent with the NMBA DMFs, with examples including "The policy says all the right things but it doesn't work in practice," "My performance appraisal was done by a non-nurse," "Asked to care for patients outside my scope," "Staff are often allocated to areas or patients that are outside their scope of practice by senior staff; some speak up, often juniors don't," "Lack of staffing makes this a requirement, " and "There is no recourse for me to take other than to lose my job if I object. Is there evidence that any organisation/employer has even been prosecuted for forcing RNs to delegate care to unregulated [health workers] who, by their very nature, do not have a defined scope of practice?" Of equal concern was the 25% of respondents who were unsure if they had been so instructed.

The ANMF believes that most nurses and midwives make decisions as an integral part of their daily practice, most often on a sub-conscious level, without unpacking or (often) being aware of the processes involved or the multiple factors that need to be taken into consideration, and therefore do not recognise the knowledge gap between their own and best practice. Some of our respondents were strongly supportive of specific education regarding the existence and use of the DMF, with responses including:

"I think a regular overview would be good for all staff," "Should be included in mandatory training," "It's something that needs to be reviewed every year and whenever there is a change or update; it is very important for all parties,"



One participant wrote: “I don’t need it, employers do, and they need to be held equally accountable, but who holds them to account, and how? This is the education that is required: those delegating are set up to fail.” This concern was echoed in other responses, including “I believe most employers and members of parliament need to be aware of an RN scope of practice, as they seem to be pushing RNs out of community nursing, which I have seen is to the detriment of clients; I’ve seen many become sick from having only [community care assistants] and ENs giving medications... respiratory infections not being picked up.”

While recognising the risk of specific examples giving some nurses and midwives the impression the DMF would only apply to those instances described, the ANMF believes that the addition of examples to the guide of the DMF in practice would increase both its usability and helpfulness, by illustrating how the principles of clinical decision making translate into practice. To ensure that the revised version is implemented by nurses and midwives when making decisions about clinical and delegation matters, we strongly recommend the NMBA promote the Framework and accompanying guide to the professions, accompanied by a roadshow, online learning and interactive education that utilises hypothetical situations that require application of the decision making frameworks.

In addition to including definitions of ‘allocation or assignment’ and ‘autonomous’ in the glossary, we request the inclusion of ‘health practitioner’, with a definition that clarifies the difference between health practitioners and health professionals (which is included in the draft). We also seek that references to ‘health workers’ be changed to ‘non-nurses and non-midwives’ (as appropriate) – while this is a subtle distinction, we believe it is important as a reminder that nursing and midwifery activities cannot be delegated to non-nurses or non-midwives.



CONCLUSION

The ANMF appreciates the opportunity to provide feedback through this submission to the public consultation on the proposed Decision-making framework for nurses and midwives. The revised Framework is an improvement on the existing documentation and guidance, however, there remain some areas of ambiguity and sections that lack clarity. Once these issues are addressed, there needs to be an extensive communication strategy to ensure the current and emerging nursing and midwifery workforce are well educated about both the existence of and content within the revised DMF. The ANMF looks forward to assisting the NMBA to communicate these changes to our members.